TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gary Erler, D.C.

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-17-0355-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $836.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2015	Designated Doctor Examination and Manual Muscle Testing	$836.30	$836.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 defines the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
6. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.

Issues

1. Is the insurance carrier's denial of payment for submission/billing errors supported?
2. Is the insurance carrier's denial of payment for medical necessity supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Dr. Gary Erler is seeking reimbursement of $836.30 for a designated doctor examination which included a determination whether the injured employee's disability was related to the compensable injury, a determination of the injured employee's ability to return to work, and manual muscle testing. These services are represented in this dispute with procedure codes 99456-W7-RE, 99456-W8-RE, and 95831. American Zurich Insurance Company (carrier) denied these services with claim adjustment reason code 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION."

   Review of the submitted documentation does not find errors in billing or submission pursuant to 28 Texas Administrative Codes §§133.10 and 133.20. Therefore, the carrier's denial for this reason is not supported.

2. Procedure code 99456-W8-RE was further denied by the carrier with claim adjustment reason code 50 – "THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A ¢MEDICAL NECESSITY' [sic] BY THE PAYER." Texas Labor Code §408.0041 states, in relevant part:

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about: …
   (5) the ability of the employee to return to work …
   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner …

   Review of available information finds that the designated doctor was ordered by the commissioner to perform an examination to determine the ability of the injured employee to return to work, in accordance with Texas Labor Code §408.0041(a). The insurance carrier's denial for this reason is not supported.

3. Because the carrier's reasons for denial of payment were not supported, the services in question will be reviewed in accordance with applicable fee guidelines for reimbursement. Per 28 Texas Administrative Code §134.204(k):

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   Further, 28 Texas Administrative Code §134.204(i)(2) states:

   > When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:
   > (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;
   > (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and
   > (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

   The submitted documentation finds that the Designated Doctor performed examinations to determine whether the injured employee's disability was related to the compensable injury and to determine the

injured employee's ability to return to work as ordered by the Division. Therefore, the correct MAR for these examinations is $750.00.

28 Texas Administrative Code §134.203(c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

For procedure code 95831 on November 7, 2015, the relative value (RVU) for work of 0.28 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.285320. The practice expense (PE) RVU of 0.56 multiplied by the PE GPCI of 1.006 is 0.563360. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.955 is 0.028650. The sum of 0.877330 is multiplied by the Division conversion factor of $56.20 for a total of $49.31. This total is multiplied by 2 units for a MAR of $98.62.

4. The total MAR for the disputed services is $848.62. The requestor is seeking $836.30. The insurance carrier paid $0.00. A reimbursement of $836.30 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $836.30.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $836.30, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.